HIT Policy Committee
Certification & Adoption Workgroup
Transcript
February 1, 2013

Presentation

MacKenzie Robertson – Office of the National Coordinator
Good afternoon everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Certification and Adoption Workgroup, and this is a public workgroup call and there is time for public comment on the agenda, and the call is also being recorded, so please make sure you identify yourself when speaking. I'll take roll call now. Mark Probst?

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
Here

MacKenzie Robertson – Office of the National Coordinator
Thanks Marc. Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Larry. Joan Ash?

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Joan. Carl Dvorak? Paul Egerman? Joe Heyman? George Hripcsak? Liz Johnson? Chuck Kennedy? Donald Rucker?

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Donald. Latanya Sweeney? Paul Tang?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Paul. Micky Tripathi? Scott White? And Marty Rice?

Martin Rice – Health Resources and Services Administration
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Marty. And any ONC staff on the line, if you could please identify yourself.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Kathy Kenyon.

MacKenzie Robertson – Office of the National Coordinator
Great. Thanks Kathy. With that, I will turn the agenda over to Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay, well welcome back for round two of this. We've got a specific charge to respond to some questions about Health IT and Patient Safety, and we're going to look to pick up the discussion from yesterday and try to see if by the end of today's call, not trying to, we will by the end of today's call, have the bulk of our response back to the Policy Committee for next week.

George Hripcsak, MD, MS – Columbia University
Hi Larry, George Hripcsak here.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
… thanks for joining.

George Hripcsak, MD, MS – Columbia University
Thanks.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, why don't we, is the next slide just going to be prepare, what's on our next slide? Yeah, okay. So there's a statement of our patient safety questions, you want to bring that one up. Thank you. So this is what we're looking to say. All the workgroup members should have a working document, it's the patient safety statement. I'm not going to ask to bring that up because it's pretty – it's Word document or PDF and it's pretty small font. But, that's the summary of our materials from yesterday's call, so, maybe we can think about going through these questions, these major headings, and … want to the first – I'll tell you what, I've got an even more focused thought here. I'm going to grab the screen and show you my working notes, okay. And then as we go, we'll update these.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
So as you're doing that Larry, so going through some of the material that people sent out to us and that we've seen, it seems the response to that first question, at least the limited response I've seen, is not positive to having an MU requirement. Is there a…either ONC or Paul, who might feel a little closer to it, do you have any additional insight into that?

Kathy Kenyon, JD, MA – Office of the National Coordinator
This is Kathy Kenyon. I did read all of the comments and the summary that you got this morning of what's in those comments is mine. If there's – if you have any questions, it was very interesting to read the comments because they, it was so consistent wanting to say something good about safety and the importance of doing some kind of a safety assessment, at the same time as they were saying, for God sake, don't put it in Meaningful Use. So, you got both … you got that sense to the comments.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, you guys should see a screen up – Health IT Safety Risk Assessment with three bullets, is that correct?

MacKenzie Robertson – Office of the National Coordinator
Yup.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, let's see if this captures the sense of what we want to say about that. I'm happy to both wordsmith or to do that offline after the fact, if you want to add some other major bullets here.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
This is Paul Tang. I certainly agree – I'm certainly sympathetic to the sentiment of not wanting to overburden providers with another large effort, probably nobody knew what we meant by safety assessment. If there were something, some brief areas to just explore and maybe – well anyways, I don't know how to word it, but I think some of the thought is, do we even think about – we could even pick some specific areas. Like let's say medication ordering. That's actually one of the areas where there are frequently errors that are facilitated by EHR use. Typically, this happens during the building of the user interface design. So, even if we pick three areas, meds is a really good example, and said, hey look, have you looked at the following things; the way – who handles the build of your … and the configuration of your med database, that knowledge base. What errors could arise in med ordering for IV infusion, that's another common error. So in other words, three things where an organization and many organizations probably have not really thought of it that way. It's almost, and maybe this is a … estation, have you thought about these kinds of errors and here are some examples, or best practices. Joan could speak to this. And that's essentially all we're opening discussion for.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. So I guess what I'm hearing Paul is, can we get people engaged in a way that's helpful, that they might actually find helpful to their process, without creating a burden.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Right. Another area – here's a, there's a safety counterpart to this, there's something called a rapid response team …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
… so in patient safety, those are folks who, oh, they're not coding, but they look bad. Well let's try to prevent them from coding. So here you could say, everything from a simple as a drug recall to an incident somebody reported should – can we, do we have the capability, that's we, a provider organization, have the capability to rapidly respond, get this core team that has a different perspective, and look at the situation and can we avert a mishap. That's a simple thing I think people would appreciate even thinking about that and putting that into place, and they've thought about having this in place. That's all we're asking. A lot – I would say the majority of providers have not thought about it, would appreciate thinking about it and it's not this big, onerous like accreditation kind of a survey.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Is there some way – this is Joan – is there some way we can very strongly encourage more work in this area and give some of these examples? And I'll put in a plug again for the SAFER Guide, it's really premature because they haven't seen the light of day yet, to push them too hard. But, on the other hand, there are other tools as well out there, that are appropriate for some organizations, not probably in the outpatient environment, but can we just say that we want the ONC to move forward very strenuously in this area and do further work. Everyone seems to think it's important, but it just seems premature to have a requirement.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, are the bullets up on the screen beginning the capture the sense of this?

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
… so, when I was listening to Paul, it was scoping it as you said Larry, and it was focusing it and giving some ideas, but I still think, Paul, you would suggest that we attest or people attest to a very scoped kind of problem statement or opportunity, is that true?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
That is true. And I – the couple of examples I gave are real ones that could be very helpful to the field and to safety. So, looking at med management or having a rapid response team to think that affects the build of the EHR.

Kathy Kenyon, JD, MA – Office of the National Coordinator
You know, I have the advantage of knowing that Joan Ash has done research on just exactly that point, because she's responsible for the SAFER Guide that looks at how you respond to, you know, the kind of people and personnel you need to respond to events. And so, I think Joan could speak to what actual healthcare organizations are finding in that area. But my sense, Joan, is that the larger facilities would have that, but not the smaller ones.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
They're the ones I would worry about and, for example a one or two person practice, and we visited some doing this research, would, I think laugh at the idea of having a rapid response team, when there are three people in the office. I mean, they'd say, oh, we're going to have an RRT, and, it would be all three of us. I don't know how much good that would do.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Now Joan …

M
…no place for that, and Joan and I agree with that…

Kathy Kenyon, JD, MA – Office of the National Coordinator
Joan has put together…

M
…are there things we could have a three physician or a three person practice look at, like Paul's saying, what we could…scope it to something that would be useful, continue to advance the ball on safety, but not ask for a complete IT safety assessment…risk assessment.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Let me…let me, you know the three person practice, there's no harm in one of those three people being the designee for when the drug recall comes in, or the methylprednisolone injection comes in, somebody's responsible for taking it off the formulary, for example.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Exactly.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Somebody does have to do that.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Yeah, that's exactly the kind of thing that's in this particular guide is that someone needs to be responsible for certain activities and so we would list that as one of the activities that someone has to be assigned.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So that's what an RRT is though, it doesn't have to be ten, it's one.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Yeah, I think as long as we made that clear.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I'm hearing language is really important here. So calling it an RRT might get us in trouble, but giving people some examples might make clear that this is not meant to be a big, onerous process, but meant to be a heads up as they're doing the work they're already doing.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Are we really saying the second bullet then or are we saying it should be, something should be required, it's just it has to be appropriately scoped.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
I think it's the latter. I'm driving so I can't see the screen, but …

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
That's good.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
It's Don Rucker. For whatever reason, I can't get on the Internet at the moment, but, I think part of this, I mean I like the rapid response stuff, and looking forward to the SAFER things. I think there's sort of – maybe some of this is wrapped up in the broader area of how people do configuration of these systems, right. Because I think that's – if you sort of have to say, where are most safety errors, obviously some are probably there's a pre-disposition to some from content providers and from the vendors and I guess at some level, but, I think if you look at most of them they are sort of at that local install stage. So is there a broader perspective we could provide, you know, like more of a prospective process type of thing, on how people install content, that would sort of get at sort of more of a preventative, more of a process thing on these safety issues. And I agree with Paul, a lot of it seems to be around drug dosing.

Kathy Kenyon, JD, MA – Office of the National Coordinator '
The evidence that we have right now from good research, and the best is the Pennsylvania Patient Safety Authority, is that the errors tend to be around medication errors. I don't know that they're around customization though. That's an empirical question that we could probably answer.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Yeah, I would actually say, it's probably about half, half of the – I think usability is a huge issue that put med errors at risk. And then the other one is the way the databases are configured. So, I think that combination, but just even alerting people that that is one of the biggest areas. The folks who are newly implementing may not know that, and that's one of the services of this kind of a reg actually. And then what can you do about it.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
I think, maybe a specific calling out, usually is stuff like you know, the pediatric dosing and the IVs and these combination things, that are just, I think, sort of hard to represent to begin with, I think is where a lot of these challenges are. It doesn't seem to be just giving a pill. So in that sense, maybe it's more of an inpatient issue. Oncology has, I think, largely gotten around this by all these double signature processes on chemo.

Kathy Kenyon, JD, MA – Office of the National Coordinator
For those of us who are working on the SAFER Guides, and I'm just the project officer, this is Kathy Kenyon. It's very encouraging to hear this conversation because we actually have SAFER Guides in all of these areas on customization and on ePrescribing and on test results review.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So Kathy, when this does come out, which of course it will before 2016, would incorporating that be sufficient for start…you know, how do we…with the testing that you have reviewed this…and I don't know what the words are, be adequate to getting a start on this?

Kathy Kenyon, JD, MA – Office of the National Coordinator
It would be more than adequate it would be overwhelming. It really is, it's set up as assessment for organizations that in some ways will be beyond what they can reasonably do. What you've been talking about is, you know, could you pick a specific thing and scope it to that, that has been very important within the meaningful use context, like for instance, around the ePrescribing, which is the area we know that there are the most HIT related errors. And that, I mean Joan, would your sense be that we could offer some insight in that area, beyond – I mean, you've got the Institute for Safe Medication Practices, which has one of the better tools out there, and we could probably pull in some people who could help the committee if it goes in the direction of recommending something in that area, get more specific.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So is there a medication subsection of SAFER Guide that we could invoke and that would not be overwhelming?

Kathy Kenyon, JD, MA – Office of the National Coordinator
We'd have to show you that. That's a judgment that I'd – we could at some point show you the SAFER Guides that results to, that relates to drug errors.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
There's one on COPE and ePrescribing that includes that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So what is the verb, is it – do they review – do they use the guide to go through a review of the different points on it and is that what we'd have people test to?

Kathy Kenyon, JD, MA – Office of the National Coordinator
Right now the guide's just, you know, and right now the guides are set up so you have recommended practices at a very high level.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Ah.

Kathy Kenyon, JD, MA – Office of the National Coordinator
And, you know, and basically you indicate how far you are along in doing that. Now, as I said, there are other tools out there that have been in use as well, the Institute for Safe Medication Practices has some kind of an assessment tool that was mentioned by many of the people who responded to the question on should you have a meaningful use risk assessment. I think that tool is in fairly wide use, but again, I have not …

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
And it's not onerous?

Kathy Kenyon, JD, MA – Office of the National Coordinator
I have not looked at it enough to know, and you'd have to take a closer look.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I think if we back up a little bit that there's this notion of a safety risk assessment and that's the thing that we want people to start engaging in, and we're now talking about particulars that might give them some sense of scope, to not make this be a huge thing, but a place to start. So, should that be the tone of what we're putting forward, that this would be really valuable, it's not widely done. We believe from the comments that it's actually misunderstood, what's being talked about, that we think it's really valuable and it should start as a menu item to give people the strong message this is something that we're bringing in scope for meaningful use. That we expect there will be guidance coming in terms of the SAFER Guide, but that there are other guides out there as well and that the goal here is to get people engaged in a risk assessment process as part of configuring and using their EHRs.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Can we limit the scope to med management then, just to help not … to help focus on an area where we know it's important.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think that's a good question, what do folks think?

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Well, I would actually recommend that we stress the nine areas that the SAFER Guides – we've been through a long process of engaging experts in identifying the nine most risky areas. Downtime events are also very risky. Lab results, big issue, so, I know where Paul is going, but if we're going to recommend just medication, that bothers me a little bit.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So I think – so, I guess where I was going was we don't want to recommend a specific, we want to recommend people engage in a process, and we give them some specifics that they might start with. But, I think this notion of the SAFER Guide has identified nine risky areas, may be in your environment, and accept this as one of them, as they shift to shift handoff. I mean, there are lots of places where you can introduce risk, we're asking people to consider safety and health IT as just a piece of the quality puzzle. So …

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
But what would we ask …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I don't want to – that message …

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
… then Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm sorry Marc, what?

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
What would we ask them to attest to under that statement?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
That they're actually doing a risk assessment, that they're doing a safety risk assessment.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Yeah, but it's too broad and it's – I think the more precise we can be, it actually reduces the overall work of burden to the entire system. There needs to either be a tool that you literally fill out or you focus at one area and provide them with tools that address that one area.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
I think it's – well, I don't know, one thought would be, what I think it was Joan that was talking, I count ten on these bullets, so maybe something's wrong on the bullets I put together. But, presenting those … but I think we do we have to get specific and you know, we can present these as something that's coming, because Joan, will these ultimately be used as a tool for a testing or what's SAFER ultimately going to be, just a guidance?

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Well, Kathy can probably speak to that.

Kathy Kenyon, JD, MA – Office of the National Coordinator
It's a self-assessment, it's just a – the kind of self-assessment tools that you see organizations doing right now. MGMA, for instance, has a very good patient safety self-assessment tool for its members, it's entirely intended for kind of private use to help people to pull Health IT issues into their ongoing safety assessment process.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
And I should also mention that we've been engaging the American Hospital Association as well as the MGMA, which is ambulatory practices, as well as the Joint Commission, so that somewhere down the pike, maybe, something will be assimilated into their already present checklist or guides. There are nine SAFER Guides plus one we call High Priority Principles, which is pretty much taking the most important things from all nine and putting them into a separate guide; that's why there are ten.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Okay, thanks.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So this very last one …

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
High Priority Principles and Practices.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Right. Would it be enough to, for attestation to say each organization should pick some sort of self-assessment tool to use? The SAFER Guides are designed so that you can use them every year if you want to, and see how you're getting better and better. I mean, really the idea is a way for the organization to set its own goals for this, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. That's where I was going.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
So what that would just say is, we would ask them to attest that they have chosen a tool or – I'm just trying to get what we're going to ask specifically as part of meaningful use.

Martin Rice – Health Resources and Services Administration
So, this is Marty, quick question. So whenever I look at when they're writing a reg, I try to figure out how it would be audited. And I'm not sure by saying they would pick a tool and then they'd do something which – and I think this is all great conversation, would, how would, if you attest to something, how do you prove that you did that? If we're telling…if we're giving them, say pick something or do this. When you have security guidelines, there's usually a specific list of guidelines that you have to follow. So – but I'm looking at it from a government face.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
That's a good way to look at it.

Martin Rice – Health Resources and Services Administration
Well, sometimes.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
Well, I really like our opportunity to highlight the SAFER work – I think is part of, again, Larry, this is kind of open to discussion, but showing those on Wednesday is a good idea, but I think we have to, if we're going to ask people to attest to something, we've got to be – I think we need to be more specific. The ambiguity is what kills us on the provider side, is trying to figure this out versus, okay, I have to do this thing, and then I can put the effort forward to get it done.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, if we pick one of these, is that the kind of focus … then a focus, say here are nine areas, pick one, have a documented plan of how this is included in your documented assessment of your risk and how this is included in your health IT planning?

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Somebody receives, somebody will have to receive that attestation and what would they do? Just say, we self-attested and all's good and then if an audit comes we can show we're …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right, show them this document, we show them that we did an assessment and this is our plan.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Yeah, that makes sense. I'm just kind of waiting for Paul to say something.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Maybe he's driven out of range.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
I'm here, I just didn't – yeah, that sounds good. So you're attesting that you have picked one of the relevant areas to your organization and somebody's gone through and documented how they've addressed that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
I like that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
(Indiscernible)

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
I do too; I think it's very positive.

M
Well, it has the advantage of drawing attention to the SAFER things explicitly.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Yeah.

M
Right? I mean, if you say, here's the list, right, you could say take it off this list of nine or ten, depending on the count.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
We got it back to nine.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
And a preamble that explains what this is and hopefully a lot of people will one, discover it and then two, make use of it. But from an attestation point, they just have to have a documented, documentation on how they address one area of importance to them.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
I think we can work with that, can't we Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think so. So, is what's up on the screen look like it generally covers what we're trying to get at? Or should I drop that whole bottom piece about the like medication ordering, like taking a drug out of formulary?

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
We probably can reword that last bullet, I think you're just trying to get clarity about the bullet right before picking one.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
In my mind, this is the key one that we're landing on.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay. We can work with that. Should we move on to reporting?

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Indeed.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, the discussion the other day seemed to focus almost on a presumption that … let me back up two slides. So I have this discussion slide, so I think it might be useful to recap some of the context we got at the beginning, that safety's part of quality, Health IT is part of safety and quality, it's both a means and risk. Contributing causes requires analysis; so that's code for saying, we don't know it's a Health IT issue until we figure out what the issue was. That we want to build on the AHRQ work, the PSO work, common format, that using PSO provides legal protections and we want to minimize burden on the users and we're looking at both proactive risk analysis and planning and also retrospective event capture and reporting. So, with that as context, it seemed like reporting was about using the AHRQ common format that EHR is only part of the safety story, so as context for what else we want to say about reporting. Do we want to recommend or start making menu options for reporting the PSOs and enabling that through the EHRs, recognizing that the EHR is really only one piece of the story.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Hello, this is Bill Munier. Can you all hear me?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yes.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
Yes.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Yeah.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Okay. I just – I would say yes to that. I'm from AHRQ and here to be a resource on the common format. One thing I would say, just for clarification purpose is that in the comments back on the, from the public that address this issue. A number of them raised very realistic concerns about whether EHRs were in fact in a position now to report on these kinds of items and in fact whether the formats themselves were tested enough to be – all kinds of issues about whether we were at a mature state enough. And some of the concerns they raised, like some of the material would not be in the electronic health record, were actually correct because the formats, as currently promulgated by AHRQ, support event reporting systems, much of the information that goes into the formats would not ever be in the electronic medical record for … because of liability concerns. But we are in the active process right now, very active, of converting those formats into a surveillance system that is driven only off medical records. So everything that we're defining is a) consistent with the formats and clinically identical to the extent possible and b) will be found in the medical record and that process will inform what could reasonably be expected to be found in the medical record.

And it's then another step to define it precisely so that vendors could actually incorporate that, but that's the direction that we're going in and it would be helpful if your deliberations support it because there is a lot of momentum, including CMS posting guidance on their website about hospitals using the format. So, there is going to be a lot of momentum toward them and if the EHR vendors will begin to nucleate around that concept, then exporting data directly from the electronic record into the event reporting systems of the hospitals and on to the PSOs will be easy. And it will go a long way toward addressing their concerns about not wanting to spend additional time collecting data that slows down productivity, a concern that we sympathize with completely.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, that's actually very, very helpful for kind of both doing two things in my mind. It sort of addresses the issues of not everything that is a safety event would be something that would be something that would be in the EHR and both raises a concern and answers the concern about the appropriateness and maturity of the reporting formats. And what I hear you say is common format is actually intended to be the output from an event analysis process and the role the EHR should be playing is capturing the initial information. That correct?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Right. And the, not to get too in the weeds about it, but the information could actually, in a mature environment it might get reported in the event reporting system first and then could actually … could populate the EHR or vice versa. And in a mature system, whichever field got populated first would go to the other one. We're looking a long way down the line, but sometimes people report an event into the event reporting system in the hospital before they put it in the medical record, or at least …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yeah.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
… initial parts of it. So, it's a dynamic field that's unfolding and hospitals will need both kinds of systems. But I agree with everything you said, I think you captured or you – I guess you understood what I was trying to say perfectly.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Well, I've lived in this world for over a decade, so I understand it way too well.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
One thing that some of my – Don Rucker – one thing some of my colleagues pointed out is that they feel that if PSOs are used as the depository that the vendors don't actually have … would not, at least in their current structure, have access to the data.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, that's an important point …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Right. So you can't – I mean, you know …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well the, what the, what would happen is that the information from the EHR would go into the hospital's local event reporting system, it wouldn't go directly to the PSO, because first of all, the hospital needs it for their own quality improvement purposes and that's the way it's functioning now. The PSOs aren't getting the information directly, they're getting it secondarily from the hospitals from their QA Departments. But you're right, if it were to go that way it would immediately be in the protected space and so, I think that wouldn't be helpful, that wouldn't be a good way to go.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Yeah, because you wouldn't have a learning environment where clearly that, I think, is needed since there's a lot of subtlety here as we've heard with the SAFER things. Do hospitals – I mean, is there a uniform standard on PSO reporting at the hospital level, skip the Healthcare IT?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, that is the common format.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
And is that being used pretty much uniformly now?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
It's …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
What's the adoption of that?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well there's enormous dynamic change now. If you'd asked me that question two years ago, I'd say virtually nobody was using it, even though formats … promulgated. A year ago I would have said a few; now it's a lot. For instance, UHC, which has sixty-eight academic medical centers, has converted their entire system to the common formats, ECRI Institute and some of the vendors like Midas and Quantros have completely converted to the format. So yes, there are hundreds if not thousands of hospitals now that are using them, so, it's changed a lot. But the ultimate goal, because a lot of people have reporting needs and we're reflecting some of the very important ones around Health IT here.

But for instance, a hospital has to report to…let's say there's a device-related IT event, say there's a…they get too much drug because of an IT error, either in the electronic health record or in an electronically operated infusion pump or something. So, they might have to report that event, depending on what happened to the patient, to their own event reporting system within the hospital, to their PSO, to the FDA, to the Joint Commission and to the state. And the idea is to be able to put the core information in the EHR once, have it populate their own event reporting system with any additional data that they require, that wouldn't go into the record, and then send it off to everybody that needs it. But in one format, that everybody has agreed on so that their not constantly being, both the hospital and the EHR vendor aren't being asked to provide the same information in different formats, depending on the requestor of the information. That's ultimately where we're trying to go. One time collection of data and provision to everywhere it's needed.

Kathy Kenyon, JD, MA – Office of the National Coordinator
In a way you can then aggregate, de-identify and use as a research base.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Exactly.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So, do we have to gate that off the installed base, or I guess if this is MU3, they would – we assume that that adoption would have been widespread by then or … I'm just a little worried. It sort of seems like some of the public health reporting things where the reporting requirements into end-receptors that don't seem to exist as assumed.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well yeah, it's a chicken and egg question and I think you're right to raise it. What I would say is that CMS, and I don't even know if it's up now, it was supposed to go up by January 31, and as of Monday of this week, it was not up, but I don't know if it's up yesterday or today, but it will be up shortly; is guidance from CMS to all hospitals that they're survey and cert folks are going to be looking to see whether hospitals are using the common formats. They have language in there like using the formats will go a long way toward meeting the QAPI requirements that are essential for CMS reimbursement. And I think that's going to boost the adoption fairly substantially, but of course, it's not … it stops short of regulation, so it's not – I can't tell you that everybody's going to do it immediately, but it should have … whenever CMS does something like that, it seems to have a fairly dramatic effect.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Bill, let me ask this. Right now as you, as we try to encourage the adoption of common formats, is … for reporting purposes, is one of the issues making certain that the EHR vendors are thinking about how it is that they can make it easier for an EHR to provide information basically automatically to a reporting app that might sit on top of the EHR and other Health IT.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, the answer to that is a simple yes. And in fact, in my view, that's the only way it will work. I mean, it may take the EHR vendors, just as with other meaningful use requirements, where they have … with their subsequent versions, they have to change some things. But the ultimate goal is to not, is to have the one-time data collection in the EHR essentially have no additional work on the part of the providers, and have automatic population, just the way you've stated it, Kathy. And in fact, we have a pilot project that ONC and AHRQ are jointly supporting, where we're looking at structured data capture from existing EHRs, to see how far they might go in populating the formats, as they exist now. And I think that'll be a very interesting project. Probably, I'll predict in advance that it's going to find that different EHR vendors represent the same clinical item in many different ways and different from the formats. And as I mentioned, the formats have some things that are predicated on a human entering them into an event reporting system, which is slightly different from what will go into the EHR. So, there's going to be a little bit of noise on both ends of the system. But nonetheless, I think it will be a very interesting project to see how close we are, in terms of getting to exactly where – what Kathy said, where there's a module that sort of sits external to the EHR, but extracts data that's already in the right format from the EHR into the event reporting system.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
I would – it's Don Rucker again – I would just caution that might be way, way harder than you think because essentially what you're asking is for the entire memory state, right, of the process, just so as a computer science thing, you know, the entire stack and heap to use specific computer science terms. Because the errant data or the errant bits or the poor EUI or whatever the thing is, could be anywhere in all of that and every system has, they have different programming languages, they have different data structures, they have entirely different ways that they represent this data internally. So, that doesn't…that overall computer state is a very, very complicated thing, right? If you just do a debugging program in memory, on a computer just running an HIT app, no other apps, so not Word or anything else, just the operating system and the app, if you were to just run a stack memory register on that, you would see there's a ton of stuff in there.

So, I suspect, since you can't prospectively necessarily state what the error is, right, there's a lot of investigation involved and manual entry. I mean, I think that's sort of the reason that, for example, a flight safety analogy would be, the cockpit recorder can be helpful, though that of course is a very, very, very simple thing, that has maybe 60 or 100 channels; here we're talking literally millions of channels potentially. But you still need an investigation of that. So, having filled out some of these forms, it's a challenge.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, I …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So I guess I'm hearing though, there might be scoping of that, because you're right, complete stack and heap is going to be huge. But, there's likely to be useful things like user, patient, major function that they're performing, recognizing that apps are going to trigger all that in very different ways.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Right. Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
(Indiscernible)

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I think all that's right and that's why I think it's – I think one of the mistakes that probably nobody on this call makes, but a lot of other people make, is assuming that once you have everything in an electronic form, it just all flows easily, and it doesn't at all. So, I completely think you're right about all this. I think the best we can do with the common formats it to lay out and define in clinical terms, English language clinical terms, very precisely what the phenomenon are that ought to be reported on any event. And that portion that should be in the record and that portion that should be added to get to understand what happened in the event and how that ought to be represented in electronic terms and then leave it to the vendors to figure out how they're going to take their application and meet that. Because all of the complexities just lay – I completely agree.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So that's an operation, just sort of to put it in … to scope it, that's sort of on the order of magnitude of doing something like a new definition of the CCD.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah. And I think we have to go slowly in that direction. I think the goal is to have common event reporting in some period of time, which is measured in years. And if we don't have a clear goal where we're getting, what the desired outcome is, we'll never get there. But, what do they say, never confuse a clear vision with a short distance.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I'm wondering if we go back to – so, I guess first question is, I've been busy trying to create a diagram on the screen while you guys have been talking …

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
No, that's fascinating.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So for those who do have Internet access, does this look like I'm beginning to tell the story? In terms of this scope issue, there was some discussion that the common format is actually not what the actual AHRQ recommendation is to come out of the EHR, because event-reporting systems have information coming from multiple sources, not just EHR, and it's a protected performance improvement environment. We're not …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
We're actually using the term common format to say common format/event reporting system and common format/surveillance and …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Ah, so, where I have initial data capture subset of the – yeah.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, I think what you have is right on the – it's correct … without … it's simple and it works.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay, so you're calling this cf/surveillance …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, but – yeah, that's fine.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay. And that might actually be a push or a pull from the EHR.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yup.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And if I recall right, some of the examples we had of the ONC challenge applications …

Kathy Kenyon, JD, MA – Office of the National Coordinator
The KBCore I think actually did …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right …

Kathy Kenyon, JD, MA – Office of the National Coordinator
… did make it easy to pull stuff.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. They were – it looked like the few that were on the website looked like they were in fact really focused more on event reporting and less on the EHR and that they were assuming that they could pull information from the EHR using one of query standards, XDS …

George Hripcsak, MD, MS – Columbia University
Is that like a huge assumption?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
On the pull side?

George Hripcsak, MD, MS – Columbia University
Well, yeah, I mean, it seems to me that – I mean I can see how you would do a demo of something, but in terms of you're going to query an enterprise database about a large amount of stuff that – I mean, I don't know, I think we just want to be careful with the scope of that assumption.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yeah, the queries were scoped. They were basically saying, here's the patient ID, send me a CCD.

George Hripcsak, MD, MS – Columbia University
Okay.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
If that raises more questions than it's worth, you could take the push or pull out, it's certainly future. I think it will work that way, but I think for now it's a push, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
That's the assumption that we're working on, that's correct.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
So what's the action by the provider organization or the provider?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
What do you mean what assumption?

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
No, what's the actual …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
What are we asking providers to do? Are we asking them to do, sorry, get back to the right screen. Are we asking them to do this piece here, that's the report to the PSO?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I don't think …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And it's not out of the HER, or are we asking them to do this initial data capture?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I think it's more along the lines of the initial data capture, isn't it?

Kathy Kenyon, JD, MA – Office of the National Coordinator
And I – my sense is then that there are two issues here. One is related to, should there be some requirement that the EHRs support reporting and the common formats. And then there is a separate question about whether you should have a meaningful use criteria on actual reporting.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
What I'm hearing though, Kathy, is the common format as it currently exists, is really not appropriate.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Well, we had moved a fair way down the roads to – I mean, Bill, I'll let you answer that one.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well, what I can tell you is that we … the common format … there are elements of the common format that will be in electronic records that are appropriate. The common formats in their entirety support near misses and unsafe conditions that will virtually never be found in the electronic record. I think what we don't want to do is publically back off getting people to move toward the common formats and we are actively engaged in converting them into the surveillance system, which will have only information that's in the common formats. And we're on a timetable where we hope to get that completed within six months. We've already been at it for about six months, and we're about half way through. So, I don't know what you're time frame is, but we're well on our way toward getting that information defined.

Kathy Kenyon, JD, MA – Office of the National Coordinator
What does AHRQ want out of EHRs when it comes to the common formats?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well if you ask me what we want, ultimately I can tell you. In terms of the next step and what we can require, which is the concrete thing that this Committee is asking for on this call, I'm not sure I know the answer to that. But ultimately, we would like to have vendors collecting primary data in the records in common…in a common way, which would be the common format/surveillance, so that they could then report out to the hospitals event reporting system in a way that would support reporting to PSOs, to FDA, to CDC, what have you, state … and we're defining the common way to do that, that will support all that. For instance, we're actively engaged with the device folks at FDA to align MedSend exactly with the common formats.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Would it be possible to encourage the EHR vendors to engage in the same way?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Sure …

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
In other words, to report the relevant …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
… an EHR is – they said at a recent meeting, they said that they were so busy trying to meet Meaningful Use 2 standards that they hadn't had time to get back to us, but they've already said that they want to meet with us because they're aware of the formats and they want to see what they can do as an organization to help their members. So, I think …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, let me back off as a once upon a time EHR developer and someone in a provider organization. The thing that would probably be helpful to me, in an organization, if someone said, I want to screen it, something looks screwy and I think it's a safety issue, is, if I've got a screen capture, so a human being can see where they were, and if I got a little bit of context of who the user was, their action and the patient.

Kathy Kenyon, JD, MA – Office of the National Coordinator
That's exactly what people are looking for.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
But that's not what I'm hearing as the core of what we're putting in common format, because that very first piece that's most useful is the screen shot. Am I correct in that assumption?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, we don't have screen shots in the common formats per se.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So …

Kathy Kenyon, JD, MA – Office of the National Coordinator
The common …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I don't want us to inhibit doing this thing that really would be helpful, because we're focused on a standard. I think we need to clarify what would be helpful, and, push the standards to do the things they're going to do well and not overburden them with things that they might necessarily do well.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, I – again, I'm sympathetic with that. Where we need to go long term – right now, AHRQ has an inventory of 70 event-reporting systems from around the country and even a few international ones. And what I can tell you is, events are defined in 70 different ways for every single event you might want to talk about, and that we just scratched the surface. There are many one-offs, homegrowns and other kinds of systems and right now, there's total chaos in terms … scientifically about how we approach patient safety and reporting things. We're trying to bring rationality to that and ultimately the EHR is going to be more important probably than anything else. So, what we want to do is encourage the vendors to know that this is where they're headed. On the other hand, if we push them to do things that are premature, we probably hurt our own cause. So I guess what I'm asking for from our point of view is for you all to work with us to support where we're going eventually, but to do it at a pace that you think makes sense, so we don't actually hurt ourselves as we get from point A to point C. But I think if we don't mention it at all, especially since I think ONC is focusing attention on it with their first mention was enormously helpful, and I think we just have to think about what makes sense at each step of the way.

Kathy Kenyon, JD, MA – Office of the National Coordinator
I'm assuming …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
That is an interesting point that the thing that's most helpful, the screen shot, is least amenable to any kind of structured data field.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well, yeah, it's a conundrum in the, in the common formats, we allow narrative, which a screen shot would be very conceptually analogous to narrative, to get collected on every individual case. And that kind – a screen shot by definition is not something that's going to be … each screen shot is going to be unique with whatever case you're talking about and, that kind of information is absolutely essential at the local level in whatever system, patient safety systems you have, has to support the collection of that unique data. And we do that in the common formats, we support the collection of data that's only useful for a single case. On the other hand, most of the data are structured fields that are defined clinically and electronically to go across different clients or different providers. And that's the whole purpose is to try and make sure that we don't define an IT event or any other kind of event, such as an adverse drug event or a pressure ulcer or anything else in different ways, depending on where we're collecting it from. And so a screen shot doesn't help toward defining things in a common way, but it's absolutely invaluable at the institution where the adverse event occurred. And it's not either/or, you have to do both. So, we're fully supportive of the concept of the screen shot as well as narrative about it.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Yeah, right now the common formats have space for that. The reporting apps that we got, the three winners, all of them start by opening something they – if the only thing that the reporting person wants to do is to put a screen shot in the reporting app, they could do that and basically the app identified who was the reporter and let them put in a few things in a narrative field, and then that … and they could have closed it at that. It then goes into the reporting system where you've got a risk manager or somebody else who then does a more thorough investigation and enters all of that structured data, that's in the common formats.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
It's interesting screen shots don't actually even need the app, right? Right, you get screen shots from the operating system.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
That's right, but …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So all you need to just do is press you know, function print screen and stick it somewhere, so …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah but the stick it somewhere is what's important, because in – if one is following the common formats, we will structure all the demographic information in a way that's consistent and, believe it or not, that's done differently everywhere, too. We'll also collect the location in the hospital and we've mapped the different … FDA, CDC, local hospitals all use different location codes. We've written a common format for that so that they … we can take CDC and FDA location codes and map them into common format locations and know whether it was in ICU or a ward, or whatever. And there's a level of harm that's assessed across different kinds of incidents. So that screen shot would be put in a context where there's a lot of common information, structured data that would help that organization to align that event with other kinds of events.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Hey Larry …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
… would it be helpful just to say the EHR should report, populate relevant fields of the common format and provide a screen shot?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, my sense is we can provide some color commentary on this. But my – and I really recognize the importance of not undercutting the momentum you're building around common format, but I want to make sure we're actually focusing on the right thing, we're not giving mixed messages. So, we're not asking EHRs to become event-recording systems, we're asking them to participate in the data collection so it's easy for someone to say, uh oh, something screwy just happened with the EHR, I want to capture that, right. I also want to be able to capture something screwy just happened with this patient, I want to say that's going on. But then you need to get back to providing care and a risk manager's going to follow up behind me using their tool, separate from the EHR, to do their work. And that's why I sort of got into drawing this picture as a way to begin to segregate the pieces and what's happening where. And the discussion we're having, I think, is really valuable and we want to engage people in this discussion, but I think we're pretty premature in terms of trying to push this into a Stage 3 Meaningful Use requirement. It might not be in a year, you know, there might be a good surveillance subset and we could really focus on that that's an important thing for the EHR to produce.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
One of the things …

M
So Larry, do clini – doctor's offices have event reporting systems?

Kathy Kenyon, JD, MA – Office of the National Coordinator
They're not required to by law, in the way that hospitals are …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Hopefully not – good scoping call here. Let's not let size blow this out of scale.

M
Well I just – anyway, just looking at your chart.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Thank you.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
One thing I would say, I think … again, I agree with everything you said. I think it's exactly right, and I appreciate your recognizing the momentum issue. What I would say is that there are people out there building links between their EHRs and their event-reporting systems, and they're doing so – they're developing their own formats for doing it. It's just your group is so influential and so important that you put a stake in the ground and say, this is where the federal governments going. AHRQ, ONC, CMS, FDA are supporting these things and this is the direction in which we're headed. Because people are out there writing code right now to support formats that are inconsistent with what we're doing, because the field is ahead of us in some ways, but they're ahead of us again, one-off, in a million different places.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, getting away from pictures to text. Picking up the earlier slide I was working on, is this the kind of message that we want to signal? That there is the AHRQ format, it's driven by event systems, that EHRs only part of the story, that, you know, maybe a little clean up in some of the wording here, that there is adoption happening for common format, that people are building links from EHRs to event-reporting and that there is a direction that we're going in, and we expect – I'm hearing you say within six months, to have a focused requirement that could be applied.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Kathy …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
… the surveillance subset?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
That strikes me as helpful, but I'm interested in your opinion.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So I can't see the words, but are we still ending up with having a requirement for EHRs to be able to push it by attaching a screen shot and be able to write about something to report it. Is that still there?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I think we should get to that when we talk about EHR standards and certification.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Okay, so what's the MU…

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
What would the provider need to do, right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Yeah. So the provider needs to encourage, has to have policies and procedures to have this happen. We don't need to force "X" number to be done, but they just – they make their users aware that here's a very easy way to capture what you were doing and tell us something … a risk or an incident. And that's all we're asking there and then we're asking the certification criteria, that vendors provide this capability. Does that make sense?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I…I feel like we're very premature for actually asking for reporting from the clinical users at this point. I agree the whole notion of we want some tools embedded in the EHR so that people can quickly say, something screwy is going on either with the system or the patient and capture that and make it available to an event-reporting system or make it available to an event-recording system or make it available within the EHR for some quality management tools, to make it something you could send to the vendor. Those all seem like useful things, but I'm also hearing we're probably ahead of standards on this.

Kathy Kenyon, JD, MA – Office of the National Coordinator
You know, I don't know if this helps, but one of the things that is in law, it was in the ACA, is that hospitals that participate in exchanges are actually required to have a contract with a patient safety organization by 2014, I think it is. So, how premature this is, because the PSOs are moving very rapidly in the direction of getting reports, adverse event reports, using the common formats. We … as we drive through the ACA, hospitals to have relationships with a PSO, we also need to make certain that the PSOs are collecting information using the AHR common formats and not whatever system they choose. And so that's … I don't know how premature this may be.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So, I'll go back to, I'll put the diagram up, what I'm hearing is requirement from the provider organization, particularly hospitals, is to provide common format to a PSO, but that that likely will be coming from an event-reporting system, not from the EHR

Kathy Kenyon, JD, MA – Office of the National Coordinator
Correct.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So Larry, I guess my concept was that the, that users of an EHR have the ability and take advantage of the ability to report something funny and capture screen shot in the context of what activity. That goes internally, it's not externally reported.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
But that is something that we don't have now and it's – it absolutely stymies any ability to even understand the risk and to act on it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. So that's a direction we want to head in, and I think it's possible by Stage 3, another year or two, that we'll have enough out there we could actually put something into the regs. We certainly should be signaling direction, we certainly should be encouraging the vendors to look to AHRQ and evolving common formats as a way to get some standards in what they're doing.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I had just one other comment, and that is that I think that rightly so, because everybody – now that EHRs are spreading more rapidly, everybody's getting freaked out over the fact that EHRs can, at times, contribute their own patient safety problems. Although I would submit that paper records can contribute the same, if – one of main reasons by being missing so much of the time, which electronic records aren't. But one of the things is that we tend to focus on IT safety, but in – the EHR really needs to be able to support the realm of reporting across all adverse events and ultimately quality as well. And so while screen shots are incredibly important, particularly for IT related problems, they're relatively less so for problems that are not IT related, but the HER needs to be broader than just IT related events.

Kathy Kenyon, JD, MA – Office of the National Coordinator
As is the common formats.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Right. Yeah, we have a fairly detailed section on IT related events, but the EHR captures all of care, so it's got to capture all of adverse events.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Right, but that could easily happen. I mean, I know at Penn it just happens on the internet, right, intranet, right. That doesn't have to be in the HIT system, it captures all the events in whatever combination of IT or non-IT might have caused that event, and on an internal website, that I'm sure we buy from somebody.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. That's very standard to have hospitals have separate event-reporting tool. And there may be a feed from …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
… not reporting …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right, there may be a feed from the EHR to kick something off; that's what Kindred does.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
You hit a choice and it says, okay, I'm now reporting something, and it prepopulates the report with you and the patient's record that you're currently in.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Exactly right and that's what we're trying to move toward being consistent with the common formats, you're exactly right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
But you're right. The hand-off we have is not common format, this system was built a decade ago.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Right.

Kathy Kenyon, JD, MA – Office of the National Coordinator
And therefore, you can't aggregate it with others or do a search on it, and that's where we're really moving.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. Well, we can do lots of internal stuff on it, but we can't – you're right, we can't aggregate it with others. But we …

M
No, there's not a minimal amount of work to make those changes either, Larry. I think you were suggesting …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
That's what I say, everybody's always in favor of a common format until they find out it's not their format.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
I think you're right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay. So maybe we need to pause this discussion, because it's already almost 4:15, talk about what we want from EHRs in terms of standards and certification criteria and then have a few minutes for public comment. Is that okay with everybody? So the scree – I'm taking silence as consent here. So, the screen that's up has some bullets from our earlier conversation and then – and I think they're really in two parts here, right? We want the systems to enable user capture and we want to somehow engage the EHR vendors.

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
Is there a timeframe when we're asking for this – I mean, not asking, but asking it be done?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So I think the implication here is, we should be gating this as either part of Stage 3 or beyond Stage 3.

Marc Probst – Vice President & Chief Information Officer, Intermountain Healthcare
I'm sure we'll get a lot more agreement if it's beyond.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Well, I guess I'm hearing, at least for the folks on this call, that this notion of a screen shot, some simple context and user text seems like it's very macro, but it seems like a level of function people would think would be important and useful. And we have the very real problem of, if people start building this, are there standards that they can be building it to today and I'm hearing is that we're close, but there isn't one today. So, if that's the package that we want to put out there, that this is something that we think is coming, that we feel is really important, that we're expecting a standard in the next six months to a year, that we're expecting to build this into Meaningful Use, but probably, and we'll have to see in terms of timing about when.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
I'd like …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So this would be the common format without the screen shot or what would – what are the standard …?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
The common formats are not inconsistent with having a screen shot where that's appropriate.

Kathy Kenyon, JD, MA – Office of the National Coordinator
In fact, it specifically would allow incorporation.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. So what I'm hearing is that rather than pushing on this becoming the event-reporting system that we think about this is a subset and you guys have been calling it the surveillance subset.

M
That looks good to me.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
And … (indiscernible) … so know that we can tolerate that much longer without this kind of data.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
It was Paul who was saying that?

MacKenzie Robertson – Office of the National Coordinator
Yeah, I think that was Paul.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Correct.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So I think my last piece here, this probably should go away. Actually, I want to replace this with what I've been saying colloquially.

M
Is that a scientific term?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Screwy, yeah. We'll see if it gets more polish by next Monday or Tuesday. A reportable event, how's that?

M
I kind of like screwy.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
… maybe we'll keep it, we need some humor in the Policy Committee. So, I guess the question that's a very real question that Paul was alluding to is, we've been talking safety and the need to better understand EHR contribution to risk, as well as EHR contribution to improved safety. What should we be doing now? And so there's one piece is the capture, right, you want something to capture …

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Event.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Go ahead.

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
No, go ahead.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'll just say there's a second piece that we've been talking about which is EHR vendors should also report to somebody. And there are a bunch of issues raised in the IOM report and in the ONC Safety Plan about barriers to providers reporting information about issues with their systems and to vendors collecting and reporting information about what they're learning. So, is it – at this point is it more appropriate to sort of surface and want to address those barriers or what? I'll toss this back to the group and your collective wisdom.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Um, it's not – well, our – couldn't we just ask the vendors reports, vendors submit reports that have been transmitted by their customers about potential safety incidents or risks?

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
Report to whom Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
PSOs.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
I don't think there's sort of a real direct mechanism necessarily for vendors to go to all the PSOs in the country, or even seek out necessarily which PSO to report to on this. I think, the other question is you're going to – on some level you might even get flooded, right, because customers are always making suggestions about they want this changed or that changed. And since this is clinical medicine, you could essentially label every one of these as a safety issue, with almost no exceptions …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I would want to really discourage that …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
… and so, I think it needs some – I think you're going to need some kind of process, I mean, probably the most straightforward is to have this stuff go to the FDA. I mean, if you're sort of looking, what's the best match of reporting things that exist in the world today that would probably be the FDA, it's a single point that can aggregate. They have some skill sets on, or they have a lot of skill sets on how to handle these things that I don't believe PSOs have. So, I think that might be a very different target and process than the whole PSO mechanism.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So, this is something that was dis – so, we had this IOM Committee and their report and they had discussed these kinds of issues and elected to take it in stages. The first stage is to use PSOs and admittedly, the desire was to have a central – some way of consolidating all this, but we have what we have. PSOs, the advantages of PSOs is that it is, it's a protected entity. So, we – let's say we state that the vendors report to a PSO, they choose, but they make it publically, they make it transparent who they are reporting to. And the IOM report was saying if things are not – if we're not happy with the results, either our understanding of the risk or actions taken to mitigate the risk, then the next stage would be the FDA …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Wouldn't it make sense though to sort of just say, if the provider thinks it's a safety thing, rather than having the vendor make the decision about whether it's a safety thing, right, because the providers are the clinicians, the vendors aren't necessarily the clinicians…

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
… so … would be if the user … the clinician user submits something as a patient safety risk or incident, then the vendor is obligated to report it on to the PSO. And yes, you'll have things that you don't consider – you know, there may be some interpretation of not being a patient safety issue, but that's up to whoever does research with all this data.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
But why wouldn't the provider report it directly?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think we've got two different things going on here, right? There's value – the provider needs to deal with this in their own environment, especially if they're trying to do risk assessments and plans. You know, something happened, we need to actually learn from this, in our own environment, independent of what the vendor does. But the vendors also, we're suggesting, would benefit from this stream of information from their users saying, "Hey, something screwy is happening," yes that's a technical term, "and we want you to know because we think you're a piece of this screwiness." And you should be able to aggregate this across all your customers and maybe you will see the pattern we don't see. Maybe not, it might be clinical, it might be patient specific or provider specific, organization process specific.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
But that wouldn't happen through the PSOs because the vendors don't have access to the PSO data.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. Right, that wouldn't happen through the PSO …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So if that can happen, I think, independently, maybe in the same format or the common format or some other format, but it seems to me that the reporting to PSO, especially since there's clinical, you know, potentially big clinical issues involved here, right, malpractice and all of that, should be coming from the provider. Maybe what the requirement should be is that there's some facilitation to have the provider send the information in two directions?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, exactly.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So, they send it to the PSO in something and then there's sort of also the option to somehow directly send it back to the vendor.

M
Yeah, and they may send it to the FDA as well, especially if we're all in the same format and they could do it easily.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So …

M
I think probably the multiple route, at least while we're finding out what works, could be very positive. One of the interesting things in talking with the FDA, why they've been so interested in PSOs is they don't feel they get a very high volume of reports, they don't feel that of the eligible events that might be reported to them, they don't think they get a very high percentage. And they're hoping that by the PSOs, which offer privilege protection from discovery that they will – even though it's anonymized, that they will get a higher volume of reports about some of these kinds of problems.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
They're not getting a high volume of reports, I think, on anything, though, right?

M
Yeah, exactly.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
I mean, they're not getting it on devices, they're not getting it on drugs, they're not getting it …

M
Yeah, that's exactly right.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
I don't think they're getting it on anything, I don't think …

M
It's enough to identify problems, but they could identify a lot more problems a lot more quickly if they got a higher volume of data.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
So Don, you're exactly right. Providers certainly have the option to report directly to PSOs. The way the IOM phrased it is, it would be voluntary for the users, the providers, it would be mandatory for the vendors. So if, in the scenario I was describing, if a customer says, hey, what's going on and reports to the vendor, the vendor must report it to PSO, the provider may voluntarily, and as this group points out, should point at anything, point out something directly to the PSO.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Paul, that's an interesting dynamic, right. So then I'm reporting on my customers to a safety organization?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Well they …

Kathy Kenyon, JD, MA – Office of the National Coordinator
And you'd have to do it in a de-identified way because if the provider is sending something to an EHR vendor, it's as a business associate and subject to HIPAA. They would be consi – the vendor would not be able to then disclose further, unless they de-identified the information.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Depends what was sent. The provider could de-identify it before it goes to the vendor.

Kathy Kenyon, JD, MA – Office of the National Coordinator
That's true.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Correct.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
The provider …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think most providers would much rather do that.

Kathy Kenyon, JD, MA – Office of the National Coordinator
Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
The provider's obligated almost to … the data up. So, so, yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
… right, we don't want to start creating patient privacy events out of this.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation & Technology Officer
Right.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So how many PSOs are there now? I read somewhere there are 80.

George Hripcsak, MD, MS – Columbia University
I think the current number is 76.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
So if there are 76 PSOs, I mean – I'm not sure how they're going to roll up to conclusion on…

George Hripcsak, MD, MS – Columbia University
Probably, there are somewhere …

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
… and resources even to, you know, disambiguate the nuances of user interface issues or computer science issues or database issues or clinical content vendor issues. I mean, it's a pretty big…seems like a funny receptacle for the information.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Well I can tell you, the skill set in the PSOs varies a great deal, some of them wouldn't have a clue what you're talking about. We also have ECRI institute and GE that have component PSOs as well as …

Kathy Kenyon, JD, MA – Office of the National Coordinator
UHC.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
… Quantros, which is a software vendor. So, it varies a great deal.

Kathy Kenyon, JD, MA – Office of the National Coordinator
And one of the things – because I had exactly that feeling when I first started looking at PSOs, this is Kathy Kenyon. Bill, am I correct that overwhelmingly you've got the PSOs out there, they are kind of the front door, they have a trusted relationship with providers. They frequently will have a backend analytics support and indeed, ECRI, for instance, does a lot of that backend support for other PSOs.

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yeah, that's right.

Kathy Kenyon, JD, MA – Office of the National Coordinator
And so, it's not as kind of dispersed and ill-informed as it might look like on the frontend. It's actually a fairly coherent group of people who know each other and know where to go for the backend analytics help. Am I correct about that Bill?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
Yes, you are.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Would there be a mechanism for the vendor to notify the customer? It's interesting, we come up with the same thing on providing meals to physicians, right, in the sales call. Right, because that's mandated reporting now. So, you know, if we give somebody four cups of Starbuck's coffee, they're going to be in a federal database as having been provided with stuff with us, which I think is going to come as a huge surprise to a lot of people, that they're on these databases. So, would there be a mechanism where when we get this back from the customer, we would say, we're obligated under Federal law to provide this to so and so PSO?

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
I don't think at the current time that's true.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
What parts not true, the meal thing?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
No the …

William B. Munier – Agency for Healthcare Research and Quality (AHRQ)
There's nothing that says a vendor has to – if a vendor voluntarily works on a patient safety issue and discloses something, I don't think there's any requirement that makes that vendor turn around and report it anywhere else that I'm aware of.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
But, I was just exploring the dynamic of … that we would be, to use a schoolyard term, being sort of a ratfink on our customers, potentially, right. If it's our fault fine, but if it's their fault…

MacKenzie Robertson – Office of the National Coordinator
So, this is MacKenzie. I just want to step in for a minute, just do the time check. It's 4:30. We can probably talk for another ten minutes, but I just wanted to bring that to everyone's attention, because we still need to do public comment as well.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Thank you. And I feel like we're sort of beating our heads – we're stuck in a rut here, and I don't have any instant way to get us unstuck, other than maybe calling a time out.

M
Could go on for hours …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right. So, does that – so I feel like we have a lot of discussion, some of which feels like its actionable, some of which feels like it's still discussion. I'm happy to take a swag at creating, you know, cleaning these slides up as something we could present to Policy Committee, circulating them to the workgroup on Monday. And maybe we could do some tweaking ahead of Monday, I mean, ahead of finalizing them, say on Tuesday, for the Policy Committee on Wednesday. That sound like a workable timeline?

Marc Probst – Intermountain Healthcare – Vice President & Chief Information Officer
I agree and I think that's good Larry.

Donald W. Rucker, MD, MS, MBA – Siemens Corporation – Vice President and Chief Medical Officer
Well, you've always done a great job before, so …

Joan Ash, PhD, MLS, MS, MBA – Oregon Health & Science University – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology
We trust you and we'll help.

MacKenzie Robertson – Office of the National Coordinator
So. This is MacKenzie and – sorry, go ahead.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yeah, help might be needed on some of this. So, why don't we time out on our discussion and open this up for public comment.

MacKenzie Robertson – Office of the National Coordinator
Sure, this is MacKenzie, I'll …

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And I'll give you the screen back, by the way.

Mackenzie Robertson – Office of the National Coordinator
Larry, if you can just have a target time of Tuesday at noon, by having the slides finalized, sent to me so we can have them printed that would be great.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Very good.

Public Comment

MacKenzie Robertson – Office of the National Coordinator
Operator, can you please open the lines for public comment?

Rebecca Armendariz – Altarum Institute
If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
We wore them out. Okay, thanks everybody for the lively discussion today. This was great.

MacKenzie Robertson – Office of the National Coordinator
All right everybody, have a great weekend.

M
Thanks Larry.